

Shared follow-up care for early breast cancer

After treatment, it is important to have follow-up visits to check whether breast cancer or DCIS has come back, to monitor side effects of treatment and to provide practical and emotional support.

Information in this Shared Care Plan will help your GP and specialists manage your follow-up care together.

Please take the Shared Care Plan with you when you visit your GP, specialist or another member of your treatment team. Ask them to record the outcomes of follow-up tests and any actions to be taken.

If you notice any new or unusual symptoms between follow-up appointments, do not wait until your next scheduled appointment. See your GP as soon as possible so that the cause of the symptom can be explored.

This Shared Care Plan:

- is only to be used by patients, GPs, specialists and other health providers as part of Cancer Australia's evaluation of shared follow-up care
- is not intended to be a complete patient history or treatment plan and does not replace the need for ongoing professional medical advice
- is not to be used as a substitute for existing referral arrangements between GPs, specialists and other health professionals
- will become active after review and sign-off by the patient, GP and specialist.

PATIENT DETAILS & CONTACT INFORMATION

Patient name		Date of birth	/	/
Address		Mobile no.		
	State	Postcode	Home /Work no.	
Support contact		Mobile no.		
Relationship		Home /Work no.		
GP name				
Practice address		Phone no.		
	State	Postcode	Fax no.	
Email address				
Specialist name		Specialty		
Address		Phone no.		
	State	Postcode	Fax no.	
Email address				

COMMENCEMENT OF SHARED CARE

Patient agreement	I have agreed to this Shared Care Plan.			
	Patient's signature _____	Date	/	/
Health professional agreements	I have reviewed this Shared Care Plan.			
	GP's signature _____	Date	/	/
	Specialist's signature _____	Date	/	/
Case conference attended?	<input type="checkbox"/> Yes <input type="checkbox"/> No			



Patient name		Date of birth	/ /
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DIAGNOSIS & HISTORY SUMMARY

To be completed by the specialist

Diagnosis date	/ /	Age at diagnosis	
Position	<input type="checkbox"/> Left <input type="checkbox"/> Right		
Histological diagnosis	Size (mm)		
	Grade	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Receptor status	<input type="checkbox"/> Oestrogen Receptor +ve <input type="checkbox"/> Progesterone Receptor +ve <input type="checkbox"/> HER2 Receptor +ve		
Menopausal status at commencement of shared care	<input type="checkbox"/> Pre <input type="checkbox"/> Peri <input type="checkbox"/> Post <input type="checkbox"/> Unknown		
Family history	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	If Yes include the number of affected maternal and paternal relatives, and indicate whether affected breast or ovarian cancer.		
	Maternal relatives		Paternal relatives
	Breast	Ovarian	Breast Ovarian
	1°		
	2°		
	Distant		
Genetic counselling	<input type="checkbox"/> Yes (provide details) <input type="checkbox"/> No		Date / /
Other health conditions/ relevant information*			
Current medications			
Known allergies			

* Include details of additional known factors that may impact on patient's risk of recurrence or approach to follow-up care.



Patient name		Date of birth	/ /
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TREATMENT SUMMARY

To be completed by the specialist

Surgery				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast surgery	<input type="checkbox"/> Breast conserving surgery	<input type="checkbox"/> Mastectomy (unilateral or bilateral)	Date	/	/
Axillary surgery	<input type="checkbox"/> Sentinel node biopsy	<input type="checkbox"/> Axillary clearance	Date	/	/
No. lymph node(s) removed	No. lymph node(s) positive				
Surgeon name				Phone no.	
Reconstruction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Method of breast reconstruction	Date	/ /
Surgeon name				Phone no.	
Radiotherapy					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
	Start date	/	/	End date	/ /
Field	<input type="checkbox"/> Breast	<input type="checkbox"/> Axilla	<input type="checkbox"/> Chest wall	<input type="checkbox"/> Other (please specify) _____	
Radiation oncologist name				Phone no.	
Systemic therapy					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Chemotherapy type	Start date	/	/	End date	/ /
Targeted therapy type	Start date	/	/	End date	/ /
Hormonal therapy type	Start date	/	/	End date*	/ /
Medical oncologist name				Phone no.	
Other issues			Imaging		
Issues requiring other specialist/allied health involvement				Date of last mammogram Result (attached)	/ /
Other specialists / allied health providers consulted					
Name & discipline				Phone no.	
Name & discipline				Phone no.	
Name & discipline				Phone no.	

* End date for hormonal therapy may be in the future.



Patient name		Date of birth	/ /
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RECOMMENDED FOLLOW-UP SCHEDULE

Date of development of follow-up schedule / /

- To be completed and agreed by the specialist and GP at commencement of shared care to document all planned monitoring. Follow-up visits should be planned for a minimum of two years.
- The standard follow-up schedule recommended by Cancer Australia is provided below to plan follow-up appointments.

Time since diagnosis	Date	Purpose of Visit	Provider name and discipline (GP or specialist)
Years 1–2 Breast cancer follow-up	/ /		
• History and clinical breast examination (CBE) every 3–6 months, and	/ /		
• Mammogram (and ultrasound if indicated) every 12 months	/ /		
	/ /		
	/ /		
Other planned reviews / monitoring as clinically required*	/ /		
	/ /		
Years 3–5 Breast cancer follow-up	/ /		
• History and clinical breast examination (CBE) every 6–12 months, and	/ /		
• Mammogram (and ultrasound if indicated) every 12 months	/ /		
	/ /		
	/ /		
Other planned reviews / monitoring as clinically required*	/ /		
	/ /		
After 5 years Breast cancer follow-up	/ /		
• History and clinical breast examination (CBE) every 12 months, and	/ /		
• Mammogram (and ultrasound if indicated) every 12 months	/ /		
	/ /		
Other planned reviews / monitoring as clinically required*	/ /		
	/ /		

* This may, for example, include a bone density (DXA) scan.

Recommended follow-up schedule following treatment for early breast cancer

Method	Years 1 and 2	Years 3 – 5	After 5 years
History and clinical examination	Every 3–6 months	Every 6–12 months	Every 12 months
Mammography (and ultrasound if indicated)	Every 12 months*	Every 12 months	Every 12 months
Chest X-ray, bone scan, CT, PET, or MRI† scans, full blood count, biochemistry and tumour markers	Only if clinically indicated on suspicion of recurrence		

CT: computed tomography; PET: positron emission tomography; MRI: magnetic resonance imaging.


*First mammogram 12 months post diagnosis; †Use of MRI may be considered in specific high risk groups.



Patient name		Date of birth	/ /
Address		Phone no.	

FOLLOW-UP VISITS & OUTCOMES

To be completed by the health professional (GP or specialist) who is the provider of the scheduled follow-up visit. Start a new page for each follow-up visit. Additional forms can be downloaded from www.canceraustralia.gov.au

Date of diagnosis	/ /	Date of this follow-up visit	/ /	Date of previous follow-up visit	/ /
Provider name and discipline					
Follow-up aims	Completed	No change	Issues identified at this visit		
Check for symptoms of local or regional recurrence	<input type="checkbox"/>				
Clinical breast examination	<input type="checkbox"/>				
Check for symptoms of distant recurrence	<input type="checkbox"/>				
Identify psychosocial issues	<input type="checkbox"/>	<input type="checkbox"/>			
Identify side effects of treatment	<input type="checkbox"/>	<input type="checkbox"/>			
Update family history	<input type="checkbox"/>	<input type="checkbox"/>			
Update menopausal status	<input type="checkbox"/>	<input type="checkbox"/>			
Update other health conditions	<input type="checkbox"/>	<input type="checkbox"/>			
Review medications	<input type="checkbox"/>	<input type="checkbox"/>			
Discuss secondary prevention of breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diet discussed	<input type="checkbox"/> Exercise discussed	<input type="checkbox"/> Alcohol discussed

INVESTIGATIONS & REFERRALS

Mammogram

Date of previous mammogram:	/ /	Is a mammogram due this visit**	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date of mammogram:	/ /	Mammogram results received:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Next mammogram due:	/ /
							Result (attached)		

Ultrasound

Is an ultrasound indicated this visit**:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date of ultrasound:	/ /	Ultrasound results received:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indication for ultrasound**:	
				Result (attached)			

Other investigations:	If yes, investigations ordered:	
<input type="checkbox"/> Yes <input type="checkbox"/> No		

Referral(s) following this visit	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, discipline

Rapid Access Request actioned?	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Next follow-up visit	/ /
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*Mammography (and ultrasound if indicated) should be conducted annually following breast cancer diagnosis. **Ultrasound may be used in addition to mammography when indicated on clinical or radiological grounds. Consider ultrasound in addition to mammography for younger women, women with dense breasts and those whose initial breast cancer could not be detected by mammography.



Patient name		Date of birth	/ /
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OUTCOME OF CONSULTATIONS WITH OTHER HEALTH PROVIDERS

e.g. Lymphoedema practitioner,
physiotherapist, psychologist

Provider Name		Discipline	
Assessment and management plan			
Date	/ /	Signature	Date of review / /
Provider Name		Discipline	
Assessment and management plan			
Date	/ /	Signature	Date of review / /
Provider Name		Discipline	
Assessment and management plan			
Date	/ /	Signature	Date of review / /
Provider Name		Discipline	
Assessment and management plan			
Date	/ /	Signature	Date of review / /
Provider Name		Discipline	
Assessment and management plan			
Date	/ /	Signature	Date of review / /
Provider Name		Discipline	
Assessment and management plan			
Date	/ /	Signature	Date of review / /
Provider Name		Discipline	
Assessment and management plan			
Date	/ /	Signature	Date of review / /

